CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MEDICAL PRACTICE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

APPLICATION FOR PHYSICIAN TRAINING LICENSURE
RESIDENTS, INTERNS, FELLOWS, HOUSE PHYSICIANS

INSTRUCTION SHEET

When to Apply

File this application when a physician is employed in an ACGME-approved ***institution located in Delaware*** and is:

- a Resident, Intern or Fellow registered in a training program outside of Delaware who will rotate through a program in in Delaware for over one month, or
- employed as a House Physician

For more information, see Section 5.2 of the Board's Rules and Regulations available online at www.dpr.delaware.gov.

Requirements for All Applicants

☐ Submit completed, signed and notarized application form.
- The applicant and Director of Training Program/Supervising Physician must sign the application in front of the notary.

☐ Enclose the processing fee of $**25.00** by check or money order made payable to "State of Delaware."

☐ If you answer "yes" to Questions 16 - 29 in the DISCLOSURES section, you must fully explain your answer. It is suggested that you use the *Physician Self-Report* form for this purpose. However, if the *Physician Self-Report* does not fully cover your situation, you may submit a signed, notarized statement in lieu of or in addition the *Physician Self-Report*.

☐ Complete the *Criminal History Record Check Authorization* form to request state and federal criminal background checks. Follow the instructions on the form to arrange to be fingerprinted.
- You must meet this requirement *even if* you recently had a criminal background check done for some other reason.

Additional Requirements for Fellows and House Physicians

If you are employed as a Fellow or House Physician, the following additional requirements apply.

☐ Submit an 8 1/2" X 11" copy of your Postgraduate Education Training Certificate(s).

☐ A personal interview with a member of the Board is required. When your application has been reviewed, the Board office will notify you whom to contact to schedule your interview.

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IDENTIFYING AND CONTACT INFORMATION

1. Full Name: _____ _____ _____
   Last First Middle
2. Other Names Used: _____ _____ _____
   (Include maiden, prior married, alternate spellings)
3. Personal Address: _____

   _____ _____ _____
   City State Zip
4. Phone: _____ _____ Email: _____
   Home Work
5. Date of Birth (month/day/year): _____
6. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐
   a. If yes, enter your SSN: _____
   b. If no, you must file a *Request for Exemption from Social Security Number Requirement*.

INSTITUTION INFORMATION

7. Enter this information about the institution ***in Delaware*** where you will be employed/trained:

   Name: _____ Department: _____

   Mailing Address: _____
   This is the address to which all correspondence, including your ACGME Training license, must be sent.

   _____ _____ _____
   City State Zip

   Phone: _____
8. Start Date of Employment/Training (month/day/year): _____
9. Type of Employment/Training (check one):

   ☐ Intern ☐ Resident ☐ Fellow ☐ House Physician
10. Do you understand that you must limit yourself solely to practice within the hospital or to medical duties outside the hospital that are assigned to you as part of your internship or resident training program? Yes ☐ No ☐

MEDICAL EDUCATION

11. Enter this information about your medical school:

    Name: _____ Graduation Date: _____

    Location Address: _____

    _____ _____ _____
    City State Zip

    If you were not a U.S. citizen when you enrolled in a medical school outside the U.S., submit 8 1/2" X 11" copy of your ECFMG certificate.

12. If you are employed as a Fellow or House Physician, enter complete information about your post-graduate training. If you are employed as an Intern or Resident, skip to Question 13.

HOSPITAL/INSTITUTION	LOCATION	DATES OF TRAINING	SPECIALTY

    If you are employed as a Fellow or House Physician, submit an 8 1/2" X 11" copy of your Postgraduate Education Training Certificate(s).

EXAMINATION AND LICENSURE HISTORY

13. Have you ever taken any of these examinations administered by the USMLE, FLEX, National Board, or State Boards? Yes ☐ No ☐ If yes, provide the following information:

EXAM	LOCATION	DATE

14. Have you ever failed a licensing exam? Yes ☐ No ☐ If yes, provide details: _____

    _____

15. Have you ever held a medical license issued by a state or U.S. territory? Yes ☐ No ☐ If yes, list *each* state or U.S. territory where you now hold, or have *ever* held, a medical license, including training licenses.

STATE/TERRITORY	LICENSE NUMBER	ISSUE DATE	EXPIRATION DATE

DISCLOSURES

If you answer "yes" to Questions 16 - 29 in this section, you must fully explain your answer. It is suggested that you use the *Physician Self-Report* form for this purpose. However, if the *Physician Self-Report* does not fully cover your situation, you may submit a signed, notarized statement in lieu of or in addition the *Physician Self-Report*. The statement should specify the state where the incident occurred, the issues involved and any further information you wish to provide.

16. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense in any jurisdiction, including any offense for which you have received a pardon? Yes ☐ No ☐

    Arrange for the Board office to receive state and federal criminal background checks.

17. Have you ever been convicted of violating the Medical or Osteopathic Practice Act of another state? Yes ☐ No ☐

18. Have you ever engaged in the practice of medicine or osteopathy without a license? Yes ☐ No ☐

19. Have you ever been refused a narcotic license or had such license modified, suspended, canceled, or prescribed narcotic drugs unlawfully? Yes ☐ No ☐

20. Have you ever willfully violated the confidence of a patient? Yes ☐ No ☐

21. Have you ever been convicted of fraud? Yes ☐ No ☐

22. Have you ever had a medical or osteopathic license denied, revoked, suspended, or limited or placed under probation? Yes ☐ No ☐

23. Have you ever had any action taken against you by the Narcotics Bureau of the Treasury Department, or the Drug Enforcement Agency of the Department of Justice or a State's Narcotic Agency in this country or any other country? Yes ☐ No ☐

24. Have you ever had a disciplinary action taken against you by a Medical or Osteopathic Society? Yes ☐ No ☐

25. Have your hospital privileges ever changed as a result of a disciplinary action taken by a hospital? Yes ☐ No ☐

26. Has a settlement ever been made or a verdict rendered against you in a malpractice action? Yes ☐ No ☐

27. Are any charges pending against you or are you under investigation regarding a felony or misdemeanor or unprofessional conduct, or professional misconduct, or malpractice? Yes ☐ No ☐

28. Are you now, or have you ever been dependent upon the use of alcohol, stimulants, or habit-forming drugs or been treated or disciplined for their use? Yes ☐ No ☐

29. Have you had either a mental or physical illness which interfered with your practice for over a month? Yes ☐ No ☐

30. Are you physically and mentally capable of engaging in the practice of medicine according to generally accepted standards, and would you submit to such an examination as the Board may deem necessary to determine your capability? Yes ☐ No ☐

If this application requires Board review, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

Applications that are not complete within six (6) months of filing may be considered abandoned and discarded. The Board office will attempt to notify you before disposing of an abandoned application.

Please note: When your application is <u>complete</u>, please allow 4-8 weeks to receive your license. A <u>complete</u> application is one that includes all required documentation and correct payment.

APPLICATIONS THAT ARE INCOMPLETE, UNSIGNED, NOT NOTARIZED OR NOT ACCOMPANIED BY THE REQUIRED PROCESSING FEE WILL BE REJECTED.

AFFIDAVIT OF APPLICANT

I swear that I am the person who executed this application, that the statements contained on this application are true in every respect, that I have not suppressed or withheld information that might affect this application, that I will abide by the laws and the ethical standards of this profession, and that I have read and understand this statement.

I affirm that I will limit my practice of medicine in Delaware to the hospital where I am employed or to medical duties outside of the hospital which may be assigned to me as part of my internship or residency training program, provided that such outside duties are performed under the supervision of a regularly licensed physician.

I further affirm that I understand that this license will expire on the day my employment with this institution ends. I agree to notify the Board office no later than three days following the end of the employment relationship.

Signature of Applicant: _____ Date: _____

VERIFICATION OF DIRECTOR OF TRAINING PROGRAM

I verify that the above-named Resident/Intern/Fellow/House Physician will be employed or participating in a training program at _____ beginning _____
Name Of Institution month/day/year

and that he/she will be under the supervision of a fully licensed physician in the State of Delaware. I further certify that the credentials of the Resident/Intern/Fellow/House Physician have been reviewed and approved. I understand that this license will expire on the day the applicant's employment with this institution ends, and I agree to notify the Board office no later than three days following the end of the employment relationship.

_____
Printed First and Last Name of the Director of the Training Program

Signature of Director: _____ Date: _____

Delaware Physician License Number: _____

STATEMENT OF SUPERVISING PHYSICIAN

I accept responsibility for the applicant's practice of medicine and surgery in this institution.

_____
Printed First and Last Name of Supervising Physician

***Signature of Supervising Physician*:** _____ Date: _____

Delaware Physician License Number: _____

NOTARY PUBLIC

State of_____, County of _____

Sworn and subscribed before me this _____ day of _____ 2_____.

Notary Public: _____

SEAL

My Commission expires: _____

Instructions for Requesting a Criminal Background Check

Criminal background checks, both federal and state, are required for all applicants for Medical licensure. **You must complete this requirement *even if* you recently had a criminal background check done for some other reason.**

Locations

Kent County – Primary Facility
State Bureau of Identification
Blue Hen Mall & Corporate Center
655 Bay Rd. Suite 1B
Dover, DE 19901
Walk-ins accepted: Mon 9 am – 7 pm, Tue - Fri 9 am – 3 pm
Customer Service: (302) 672-5319

New Castle County - Satellite Facility
State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(Between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility
Delaware State Police Troop Four
South DuPont Hwy & Shortley Rd.
Georgetown DE 19947
(Across from DelDOT & the State Service Ctr.)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants Residing in Delaware

1. If you are using the New Castle or Sussex Counties locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.

2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of $69.00 to cover both the State and Federal criminal checks. As fees are subject to change, contact the agency where you plan to submit your forms for current fees. Cash, money orders and credit cards other than American Express are accepted. *Personal checks are not accepted.*

Out-of-State Applicants

1. You can be fingerprinted by your local police agency. All types of fingerprint cards are accepted. If your local police agency cannot provide a fingerprint card, call **(302) 672-5319** to request a fingerprint card.

2. Send your *Authorization for Release of Information* form, fingerprint card, and $69.00 fee (by personal check or money order) to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

⇨ ***Allow four weeks for receipt of results.***

DO NOT SEND THE FORM OR FEE TO THE BOARD OF MEDICAL PRACTICE OFFICE!!

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AUTHORIZATION FOR RELEASE OF INFORMATION
CRIMINAL HISTORY RECORD CHECK

REASON FOR REQUEST: **Delaware Board of Medical Practice - License Application**

_____ _____ _____ _____
LAST NAME FIRST NAME MI SUFFIX

ALL OTHER NAMES USED IN THE PAST:

1. _____
2. _____
3. _____
4. _____

MAIL THE RESULTS OF MY CRIMINAL HISTORY REQUEST TO THE ADDRESS I HAVE DESIGNATED BELOW:

Name/Company: **Delaware Board of Medical Practice**

Address: **861 Silver Lake Boulevard, Suite 203**

City/State: **Dover, DE 19904**

AUTHORIZATION TO RELEASE INFORMATION:

As an applicant, I authorize release of any and all information that you have concerning me, including **CRIMINAL HISTORY RECORD INFORMATION** and other information of a confidential or privileged nature. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____**DATE:** _____

Phone Number Home: _____ Work: _____

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.